

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement for office visits, injections, radiologic exam, and reports.
- b. The request was received on April 5, 2001.

II. EXHIBITS

1. Requestor, Exhibit 1:
 - a. TWCC 60 and Letter Requesting Dispute Resolution
 - b. HCFA's
 - c. EOB
 - d. Medical Records
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit 2:
 - a. TWCC 60 and/or Response to a Request for Dispute Resolution
 - b. HCFA's
 - c. Audit summaries/EOB
 - d. Medical Records
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on August 12, 2002. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on August 15, 2002. The response from the insurance carrier was received in the Division on August 8, 2002. Based on 133.307 (i) the insurance carrier's response is timely.
4. Notice of Medical Dispute is reflected as Exhibit #3 of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: The requestor states in the correspondence dated April 3, 2002 that...
“[Injured Worker] was referred to this office by his treating physician... on April 9, 2001 for a work related injury on ___ to his left upper extremity. My next follow-up with him was May 14, 2001, at which time he was given a left shoulder injection with instructions to return in 6 weeks for a second injection unless the initial injection is ineffective. If the injection was indeed ineffective, I would schedule him for surgery. At the second visit, the patient had improved to the extent that I did not do a second injection. By August 29, 2001, there was a definite need for another injection and surgery was again discussed if improvement was not noted. The patient did receive surgery on November 6, 2001 which was approved and paid for. I am filing this appeal due to the lack of payment for the first two office visits. This patient did go through a hearing and won his case, thus is covered by Worker’s Compensation for his injury. My office filed and refiled the charges that remained unpaid (4-9-01 and 5-14-01) and spoke by phone to the adjuster who proclaimed they would be paid back in September of 2001... To this date I still have no payment...”
2. Respondent: The respondent states in the correspondence dated April 3, 2002 that...
“...these two dates of service both reflect diagnosis code for cervical. The agreement at CCH as indicated in ___ note dated 8/15/02 did not include cervical. We show no record of calls from ___ office for these dates, nor do bill notes reflect any ‘Request for Reconsideration’ being filed by his office...”

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on April 9, 2001 and extending through May 14, 2001.
2. Although the diagnosis codes on the HCFA-1500’s indicate cervical, the clinical notes for these dates of service indicate treatment was rendered to the left shoulder and elbow, which are the body areas that were adjudicated as compensable.
3. Requestor has submitted HCFA-1500’s which are stamped “Request for Reconsideration” in accordance with Rule 133.304(k)(1)(A).

3. The following table identifies the disputed services and Medical Review Division's rationale:

Reference:							
DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MARS (Maximum Allowable Reimbursement)	REFERENCE	RATIONALE:
04/09/01	99245	\$250.00	\$0.00	T28 (R)	\$201.00	MFG, E/M(IX)(A) & (D)(1)	Compensability issues resolved in a Contested Case Hearing 8/6/01. Claimant sustained a compensable injury to his left shoulder and left elbow.
	73030-WP	\$75.00	\$0.00	T28 (R)	\$24.00	R/NMGR(I)(A) (2)	
	99080-73	\$15.00	\$0.00	T28 (R)	\$15.00	Rule 129.5(d)(1)	Clinical notes support treatment was rendered to the compensable body area and billed per the MFG and TWCC Rules; therefore, reimbursement In the amount of \$240.00 is recommended.
05/14/01	99214-25	\$85.00	\$0.00	R	\$71.00	MFG, E/M(IV)(C)(2)	Compensability issues resolved in a Contested Case Hearing 8/6/01. Claimant sustained a compensable injury to his left shoulder and left elbow.
	20610	\$100.00	\$0.00	R	\$40.00	MFG. SGR(B)(1) & (E)(4)(a, b & e)	
	99070ST	\$100.00	\$0.00	R	DOP		
	J2000	\$18.00	\$0.00	R	DOP		
	J1100	\$18.00	\$0.00	R	DOP		
	99080-73	\$15.00	\$0.00	R	\$15.00	Rule 129.5(d)(1)	Clinical notes do not support the higher level of office visit per the MFG. Therefore, reimbursement is not recommended.
							Clinical notes support injections were rendered as billed; therefore, reimbursement in the amount of \$76.00 is recommended.
							Requestor did not document the sterile tray charges per the MFG rule referenced; therefore, reimbursement is not recommended.
							TWCC-73 submitted supports the reimbursement per the Rule referenced; therefore, reimbursement in the amount of \$15.00 is recommended.
Totals		\$876.00	\$0.00				The Requestor is entitled to reimbursement in the amount of \$331.00

VI. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit \$331.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

This Order is hereby issued this 23rd day of January 2003.

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf